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Medicaid Work Requirements:
State-Based Innovation or Punitive Policymaking?

An Undergraduate Honors Thesis
Submitted in Partial fulfillment of
University Honors Program Requirements
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by
Diane Sherwin, BS
Forensic Science
College of Agricultural Sciences and Natural Resources

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Faculty Mentor:
John Gruhl, PhD, Political Science

Abstract

In March 2017, officials appointed to the Center for Medicare and Medicaid Services by President Donald Trump signaled to state governments their intent to support states who would choose to utilize Medicaid's Section 1115 waiver provision to alter their state's Medicaid program by introducing a work requirement. As of October 1, 2018, 13 states have heeded this signal and proposed a work requirement component for their Medicaid programs. The purpose of this paper is to determine if Medicaid work requirements are an innovative policy approach to improve independence among Medicaid enrollees, or if these requirements are a punitive, partisan approach to policymaking. To study this question, I reviewed the literature about Medicaid and work requirements of other federal welfare programs, conducted an examination of several aspects of each state's waiver application, and reviewed the results from other research and from Arkansas, the first state to implement their work requirement. After conducting this analysis, I have concluded that Medicaid work requirements are a punitive and ineffective policy approach whose purported benefits do not outweigh the difficulties they place on enrollees.

Key Words: Medicaid, health policy, work requirements, political science, health insurance, public health

Dedication

I wish to express my appreciation to Dr. John Gruhl for his valuable assistance in choosing a research topic, answering any questions I had throughout this process, providing useful feedback, and advising me from the beginning to the end of this project. Your advice was sincerely appreciated. I also wish to thank my family and friends for supporting and lifting me up while I worked on this project for the past year.

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Introduction and Literature Review

What is Medicaid?

Medicaid is a means-tested, needs-based social welfare program in the United States that provides health insurance coverage to the low-income people it serves.¹ Originally created under the name Title XIX as a part of the 1965 amendments to the Social Security Act of 1935, Medicaid was the national health program associated with President Lyndon B. Johnson's Great Society scheme.² Prior to 1965, interest in some sort of national health insurance coverage was high, but health insurance was not linked to other programs that came out of the Great Depression era for fear that any health care provisions would induce special interests to lobby to kill such a bill.³ All states have participated in Medicaid since 1982.⁴ As of November 2018, at least 66.1 million Americans are covered by Medicaid.⁵

Medicaid is a program that is commonly confused with Medicare, another US health insurance program. The two are similar in that they provide health insurance for a population of citizens. Medicare is a federally funded and administered program to provide insurance for retirees, their spouses, and certain disabled workers.⁶ Medicaid covers those who are low-income, pregnant, or disabled.⁷ It is a federally funded program but is administered by the states.⁸ This distinction surrounding administration has precipitated the circumstances that allow for work requirement regulations, the topic of this research, to occur. States are given great flexibility in regard to the specifics of their Medicaid programs, including control over who is

¹ "A Brief History of Medicaid," Office of the Assistant Secretary for Planning and Evaluation.

² "Social Security Act Amendments," Association of the Centers for the Study of Congress.

³ Ibid.

⁴ "A Brief History of Medicaid," Office of the Assistant Secretary for Planning and Evaluation.

⁵ "November 2018 Medicaid & CHIP Enrollment Data Highlights," Centers for Medicare and Medicaid Services.

⁶ "A Brief History of Medicaid," Office of the Assistant Secretary for Planning and Evaluation.

⁷ Ibid.

⁸ Ibid.

eligible for Medicaid in their state, how the program is administered, the scope of the program, the type of services covered by the program, and the payment rates received by those who treat patients covered by Medicaid.⁹ The federal government sets requirements for Medicaid through its Centers for Medicare and Medicaid Services (CMS), which outlines baseline service delivery, quality, funding, and eligibility standards.¹⁰ As a result of this federal-state partnership, coverage through Medicaid varies wildly in its quality for those it serves.¹¹ The fragmented nature of the administration of Medicaid means that determining a cohesive picture of the program's outcomes can be challenging. My research is necessary because it attempts to piece together such a picture on a relevant and evolving health policy issue: the work requirements imposed on Medicaid members by the governments of some states.

Medicaid and the Affordable Care Act

The Patient Protection and Affordable Care Act (commonly known as “Obamacare” or the ACA) is a sweeping law instituting reform in several areas of US health care that was passed in 2010. Medicaid was one of the areas in which the ACA sought to reform, most notably by instituting Medicaid expansion. The general goal of Medicaid expansion was to decrease the number of uninsured Americans, especially those in low-wage or part-time jobs whose employers did not offer insurance.¹² This was a departure from Medicaid in prior years—before Medicaid expansion, coverage via Medicaid was only attainable for those who were very poor or disabled.¹³ With Medicaid expansion, single, childless adults were now eligible for Medicaid coverage in some states.¹⁴

⁹ Ibid page 5.

¹⁰ Ibid.

¹¹ "Medicaid, Children's Health Insurance Program, & Basic Health Program Eligibility Levels," Centers for Medicare and Medicaid Services.

¹² "The Affordable Care Act: Objectives and Likely Results in an Imperfect World," Silvers.

¹³ Ibid.

¹⁴ Ibid.

Members of the Republican party were staunchly opposed to the ACA and to Medicaid expansion. Interestingly, portions of the ACA were originally ideas whose genesis was attributed to Republican politicians and think tanks (for example, Mitt Romney attempted implementation of a version of the individual mandate as governor of Massachusetts in 2006).¹⁵ The individual mandate was also written into legislation proposed in 1993 by conservative senators working on health reform in that era.¹⁶ Several of those senators were still a part of the body in 2009 when debate on the ACA began in earnest but ended up flipping their positions on the mandate and some other ideas.¹⁷ A well-documented campaign by the GOP to oppose the health law was launched—partially as a way to oppose everything proposed by President Obama simply because he was the one advocating for it.¹⁸ After conservative media sources began prominently blasting the ACA and promoting the Tea Party, certain district court judges began to give merit to shaky legal arguments that would decimate the ACA.¹⁹ The House of Representatives then made at least 67 symbolic votes signaling their desire to repeal the ACA (almost all lacking any serious attempt at a replacement plan).²⁰ The Koch brothers sponsored an aggressive ad campaign that put implementation of the ACA in doubt, and libertarian organizations took steps to convince young people to purposely sabotage the Act so as to better “defend their freedom”.^{21,22} Journalist Sarah Kliff of the *Washington Post* described in 2013 the efforts of these libertarian groups:

¹⁵ “Unpopular Mandate,” Klein.

¹⁶ Ibid.

¹⁷ Ibid.

¹⁸ Ibid.

¹⁹ Ibid.

²⁰ “House Votes - Again - to Repeal Obamacare – CNNPolitics,” Walsh.

²¹ “Conservatives' Aggressive Ad Campaign Seeks to Cast Doubt on Health Law,” Peters.

²² “Inside the Obamacare Resistance,” Kliff.

*“Since it’s difficult to make an argument from self-interest against accepting free money to buy health insurance, anti-enrollment campaigns have pinned their hopes to framing the health law as a government handout – all financed by the young and the healthy. They’ll describe it as something akin to welfare or food stamps, and expect that middle-class Americans will then think twice about enrolling.”*²³

This philosophy of branding becomes particularly interesting when you consider the findings of social scientists who have studied the general attitudes that political conservatives hold towards the poor, the concept of individualism, and welfare. Research by sociologists like Cozzarelli, Wilkinson, and Tagler has found that political conservatives are more likely to believe that poverty is caused by individual issues, not societal issues.²⁴ In their studies, compared to other political ideologies, conservatives were found to consistently hold fewer positive feelings towards the poor.²⁵ Conservatism was also shown to correlate positively with a belief in the importance of individualistic causes, controllability, blame, and anger, according to Zucker and Weiner.²⁶ In their research, a negative correlation was found between conservatism and perceptions of the importance of societal causes, pity, and intentions to help.²⁷

Actions by GOP elected officials to undermine or repeal the ACA have continued with the approval and assistance of the Trump administration. Members of Congress came very close to repealing the ACA in July of 2017, and only just failed in doing so.²⁸ In August of 2017, the White House reduced funding for grants that provided trained advisors who assist people in enrolling in the exchange marketplace, as well as reduced the advertisement budget for ACA

²³ “Inside the Obamacare Resistance,” Kliff.

²⁴ “Attitudes Toward the Poor and Attributions for Poverty,” Cozzarelli, et. al.

²⁵ Ibid.

²⁶ “Conservatism and Perceptions of Poverty: An Attributional Analysis,” Zucker, et. al.

²⁷ Ibid.

²⁸ “Republican Effort to Repeal the ACA, July 2017,” Ballotpedia.

enrollment by 90%.²⁹ October 2017 was marked by President Trump ending subsidy payments to insurers that helped reduce the out-of-pocket costs paid by low-income ACA enrollees.³⁰ In December 2017, Congress also reduced the individual mandate penalty for going without insurance coverage from a penalty of nearly \$700 to \$0.³¹ As the individual mandate was a useful tool for keeping prices low for the citizens who received their health coverage through the insurance exchanges the ACA established, this penalty reduction was considered an act of sabotage. Between June and August of 2018, the Trump administration also issued rules that allowed business, groups, and some individuals to buy health insurance that did not meet ACA-required coverage of certain benefits (such as emergency care, prescription drugs, and mental health services).³² These plans have had a history of fraudulent activity associated with them.³³

The adoption of Medicaid expansion was initially a requirement under the ACA. States who refused to implement the expansion were slated to lose their Medicaid funding. The requirement to enact Medicaid expansion was championed as a way to lower the uninsured rate in the United States.³⁴ However, this provision was eventually struck down as part of the multifaceted lawsuit *National Federation of Independent Business v. Sebelius*.³⁵ In the suit, which reached the Supreme Court, three issues were debated:

- Was the individual mandate provision unconstitutional under the Anti-Injunction Act?

²⁹ "Wobbly but Upright, Obamacare Still Standing in Michigan," Bridge Staff.

³⁰ Ibid.

³¹ "The GOP Tax Bill Repeals Obamacare's Individual Mandate. Here's What That Means for You," Mukherjee.

³² "Wobbly but Upright, Obamacare Still Standing in Michigan," Bridge Staff.

³³ Ibid.

³⁴ "The Affordable Care Act: Objectives and Likely Results in an Imperfect World," Silvers.

³⁵ "Florida v. Department of Health and Human Services," Kiera.

- Was the individual mandate a valid exercise of Congress's Taxing Clause powers?
- Was the Medicaid expansion provision a valid exercise of Congress's spending powers?³⁶

The first two questions are not of extreme relevance to the research of this paper. However, the expansion of Medicaid and how this has played out thus far provides some interesting insight to work requirement proposals. The ACA's requirement that all states implement Medicaid expansion or lose all Medicaid funding was considered by the Court to be an unconstitutional exercise of Congress's spending powers.³⁷ The Court considered the clause in the ACA to be unconstitutional because Medicaid is a program that is jointly implemented by the federal government and the states, similar to the Supplemental Nutrition Assistance Program (SNAP, referred to colloquially as "food stamps").³⁸ Due to that joint aspect of implementation, a majority of justices felt that the "join in or lose your funding" provision in the ACA went beyond the acceptable level of federal rule-setting regarding Medicaid.³⁹

After the decision came down in *NFIB v. Sebelius*, several states opted not to implement Medicaid expansion, though an increasing number have reversed this choice in the years since. As of September 2017, 32 states had opted to expand their Medicaid programs.⁴⁰ In the time since, voters in multiple other states have approved Medicaid expansion via ballot initiative.⁴¹ The aftermath of the *NFIB v. Sebelius* ruling allowed the differing attitudes between states regarding Medicaid to fester and grow even more pronounced. There's now a strange dichotomy

³⁶ "Florida v. Department of Health and Human Services," Kiera.

³⁷ *Ibid.*

³⁸ *Ibid.*

³⁹ *Ibid.*

⁴⁰ "Medicaid Expansion Enrollment," Henry J. Kaiser Family Foundation.

⁴¹ "Three Red States Vote to Expand Medicaid during an Election Where Health Care Was the Top Issue," Pramuk.

between states that are attempting to increase the enrollment in their Medicaid programs and the states who are antagonistic to the idea of expansion. Changing state political landscapes have also contributed to this dichotomy: of the states proposing work requirements for their Medicaid programs, there are both states that expanded Medicaid and states that have firmly opposed expansion. While a portion of the states proposing work requirements that expanded Medicaid were governed by Democrats at the time of expansion, the ideological bent of those proposing work requirements presently takes a different direction. Of the 13 states I studied for this project, all 13 were led by Republican governors and every one of their state legislatures were controlled by Republicans or some sort of moderate-conservative coalition.

What are Work Requirements?

It is important to understand what work requirements are when deciding if they align with or subvert the purpose of Medicaid. Being cognizant of the full reality of work requirements is essential to determining if these regulations are good faith policy efforts to help citizens, or if they are punitive measures designed to focus on a state's bottom line. Work requirements are regulations that have been posed as part of the broad umbrella of "welfare reform", a package of ideas which are designed to keep welfare systems from spending too much money, increase self-sufficiency and make sure people no longer need to rely on welfare benefits.⁴² This stated purpose sometimes has unintended consequences (such as when people sometimes make enough to pass a monetary threshold and get off the SNAP rolls, but that increased income is not enough to replace what they were able to buy with SNAP, leaving them in a worse position than when they received SNAP benefits).⁴³ In the instance of Medicaid work requirement proposals, states have attempted to require Medicaid recipients to participate in approved activities (such as

⁴² "Medicaid Enrollees and Work Requirements: Lessons From the TANF Experience," Musumeci, et. al.

⁴³ Ibid.

employment, job training, or education) as a prerequisite to receiving health coverage through Medicaid. If a Medicaid recipient fails to meet this “work requirement”, they will lose their insurance coverage through Medicaid. Because of the precarious economic positions many Medicaid recipients find themselves in, they may be unable to afford any other private form of health insurance and will then face the numerous, well-documented challenges posed by being uninsured.⁴⁴

Some of the first mentions of work requirements can be found in the proposed (but not passed) Nixon Family Assistance Plan of 1969-1972.⁴⁵ Nixon and his administration proposed a plan that they hoped would simultaneously combat national dependence on welfare and decrease poverty: a plan that would create a universal basic income after establishing work requirements to receive that income.⁴⁶ In the Family Assistance Plan, families would be provided with a base amount of income with the requirement that they must find work or enroll in job training.⁴⁷ This requirement was to apply to all working-age adults besides single mothers with children under the age of three.⁴⁸ While the Nixon Plan didn’t pass, it did become a sort of blueprint that was followed during the major welfare reforms of the 1990s.

In 1996, President Clinton signed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), a sweeping law that gave states (instead of the federal government) control of their welfare programs.⁴⁹ As a part of PRWORA, the Temporary Assistance for Needy Families (TANF) cash assistance program was created. This program gave states block grant funding to provide cash to adults, with children, who are participating in the

⁴⁴ "Why Some Americans Are Risking It and Skipping Health Insurance" Tozzi.

⁴⁵ "#FamiliesSucceed: President Nixon's Family Assistance Plan," Richard Nixon Foundation.

⁴⁶ Ibid.

⁴⁷ Ibid.

⁴⁸ Ibid.

⁴⁹ "Medicaid Enrollees and Work Requirements: Lessons From the TANF Experience," Musumeci, et. al.

workforce and in serious need of cash assistance.⁵⁰ TANF has several work requirement provisions that are quite specific, detailed, and complicated. Stated policy goals of TANF and PRWORA included making people less reliant on welfare, increasing employment, and increasing levels of independence.⁵¹ However, studies examining TANF work requirements found that the work requirement had little impact on increasing employment of TANF recipients.⁵² These recipients remain in low-paying jobs, and those who faced barriers to employment were unable to overcome these barriers even with the incentive of receiving TANF for doing so.⁵³ Researchers from the Department of Health and Human Services found in 2001 that there was “virtually no difference in income and employment between those (in TANF) who were subjected to work requirements and a control group that was not.”⁵⁴ Studies also found that TANF work requirements placed undue burdens on state administrative agencies to comply with federal regulations under PRWORA.⁵⁵ Outcomes from TANF are a useful reference material when making conclusions about the effectiveness of Medicaid work requirement proposals.

Medicaid Work Requirement Proposals

Drawing on conditions of antagonism towards Medicaid expansion and generous welfare structures, lawmakers in several states departed from the historical, normative purpose of Medicaid and presented work requirement proposals for their Medicaid programs to the federal government throughout 2017 and 2018.⁵⁶ These proposals arrived after the federal Department of Health and Human Services and CMS signaled to state’s governors in a March 2017 letter that

⁵⁰ "Medicaid Enrollees and Work Requirements: Lessons From the TANF Experience," Musumeci, et. al.

⁵¹ Ibid.

⁵² Ibid.

⁵³ Ibid.

⁵⁴ "Wisconsin is the GOP Model for 'Welfare Reform.' But as Work Requirements Grow, so Does One Family's Desperation," Samuels.

⁵⁵ "Medicaid Enrollees and Work Requirements: Lessons From the TANF Experience," Musumeci, et. al.

⁵⁶ "Understanding the Intersection of Medicaid and Work," Garfield, et. al.

they would be open to proposals designed to improve the integrity and effectiveness of state's Medicaid programs.⁵⁷ These proposals are allowed for via a mechanism called an 1115 waiver.

The 1115 waiver refers to Section 1115 of the Social Security Act of 1965 and allows states to run experimental or pilot programs to attempt to improve their Medicaid programs.⁵⁸ Receiving an 1115 waiver gives states the flexibility to tailor their Medicaid programs around certain policy goals that reflect state-specific cultures.⁵⁹ Under non-codified precedent, 1115 waivers have to be budget-neutral for the federal government in order to gain approval.⁶⁰ Theoretically, 1115 waiver projects are a necessary way to serve the diverse population that receives Medicaid, account for differences between states, and provide a platform for experimentation that could lead to improved health and economic outcomes under Medicaid.⁶¹ This experimental attitude is encapsulated best in a quote by former Supreme Court Justice Louis Brandeis in his 1932 dissent in *New State Ice Co. v. Liebmann*:

*"It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country."*⁶²

While 1115 waivers have existed since the passage of Medicaid into law in 1965, they were not used with any frequency until the mid-1990s.⁶³ Since then, each administration has chosen to approve waivers that align with their differing health policy priorities. For example, CMS under the Obama administration chose to prioritize approval of 1115 waivers that

⁵⁷ "How Medicaid Section 1115 Waivers Are Evolving: Early Insights About What to Watch," Rudowitz, et. al.

⁵⁸ "The Role of Section 1115 Waivers in Medicaid and CHIP: Looking Back and Looking Forward," Artiga.

⁵⁹ "About Section 1115 Demonstrations," Centers for Medicare and Medicaid Services.

⁶⁰ Ibid.

⁶¹ "About Section 1115 Demonstrations," Centers for Medicare and Medicaid Services.

⁶² 285 U.S. 262, 311 (1932).

⁶³ "The Role of Section 1115 Waivers in Medicaid and CHIP: Looking Back and Looking Forward," Artiga.

implemented Medicaid expansion in the states.⁶⁴ CMS under the Trump administration outlined these priorities that state lawmakers should consider when proposing a section 1115 program:

1. Improve access to high-quality, person-centered services that produce positive health outcomes for individuals;
2. Promote efficiencies that ensure Medicaid's sustainability for beneficiaries over the long term;
3. Support coordinated strategies to address certain health determinants that promote upward mobility, greater independence, and improved quality of life among individuals;
4. Strengthen beneficiary engagement in their personal healthcare plan, including incentive structures that promote responsible decision-making;
5. Enhance alignment between Medicaid policies and commercial health insurance products to facilitate smoother beneficiary transition; and
6. Advance innovative delivery system and payment models to strengthen provider network capacity and drive greater value for Medicaid.⁶⁵

In addition, Trump administration officials, including Seema Verma (head of CMS), have sent mixed messages about the purpose of Medicaid work requirements. Verma, along with former head of the Department of Health and Human Services Tom Price, in a letter to state governors in 2017 stated the following:

*"We are going to work with both expansion and non-expansion states on a solution that best uses taxpayer dollars to serve the truly vulnerable."*⁶⁶

⁶⁴ "How Medicaid Section 1115 Waivers Are Evolving: Early Insights About What to Watch," Rudowitz, et. al.

⁶⁵ "About Section 1115 Demonstrations," Centers for Medicare and Medicaid Services.

⁶⁶ "Improving Medicaid," Price and Verma.

This first letter to the states put an emphasis on budgeting and saving taxpayer dollars rather than Medicaid recipient health outcomes. Then, in September 2018, Verma said the following when faced with the first results of Arkansas's approved waiver program:

*"Community engagement requirements are not some subversive attempt to just kick people off of Medicaid...Instead, their aim is to put beneficiaries in control with the right incentives to live healthier, independent lives."*⁶⁷

This statement puts more of a focus on health outcomes for Medicaid beneficiaries.

Materials and Methods

One of the requirements of 1115 waiver proposals is that they are made public and are free to access on Medicaid.gov.⁶⁸ These proposals are also required to include very detailed information about the program a state hopes to implement, such as: goals and objectives of the program, descriptions of the proposed care delivery system, eligibility requirements, and benefit coverage, costs to individuals impacted by the program, estimates of anticipated increases or decreases in Medicaid enrollment, and research hypotheses and plans for testing these hypotheses. Due to these specifications, careful study and evaluation of the 1115 waiver applications of each state who hopes to implement work and community engagement requirements is an effective way to analyze the intentions of the lawmakers who suggest Medicaid work requirement proposals.

For this project, I downloaded and studied the 1115 waiver applications for 13 states who had submitted their proposals to CMS for approval before October 1, 2018. A link to and citation of every state's waiver proposal is included in the appendices. I examined what type of activities each state considered as fulfillment of the work requirement (employment, higher

⁶⁷ "Trump Administration Defends Medicaid Work Requirements," Hellmann.

⁶⁸ "State Waivers List," Centers for Medicare and Medicaid Services.

education, job training, etc.) to determine if there was commonality between the types of activities allowed and if the states took a liberal or more constricting approach to defining what activities could be considered “work”. I examined the conditions in which each state would allow a Medicaid recipient to be exempt from the work requirement (disability, pregnancy, etc.) to determine if there was commonality between the types of exemptions allowed and if the states took a liberal or more constricting approach to understanding what conditions may prevent Medicaid recipients from participating in the workforce. I examined the consequences states would lay if a Medicaid recipient failed to comply with the work requirement to determine if there were any commonalities between states. To better understand the broad versus constricting designation for each program, I examined what ages for a Medicaid recipient each state would consider exempt from the work requirement. I examined the number of hours a state would require a Medicaid recipient to work to comply with the work requirement under their Section 1115 waiver proposal. For this paper, I also considered which states did and which states did not expand Medicaid, as well as whether or not the states proposing work requirements were litigants in *NFIB v. Sebelius*. I considered the party affiliation of the governor and majority party of the state legislature for each state proposing a work requirement at the time the work requirement was proposed. I compiled these results in Microsoft Excel and created easy-to-read charts in the results section below. Through the completion of this research, I hope to answer the following question: are Medicaid work requirements an innovative way to assist Medicaid recipients, or are they a punitive way to lessen the budgetary burden on states, while sacrificing the health of the citizens served by Medicaid?

Results

This results section aggregates the results of the examination of each state's proposals and displays some of the commonalities between the proposals in chart form. Further, in-depth spreadsheet analysis that includes every work requirement facet of each state's proposals is included in the appendices.

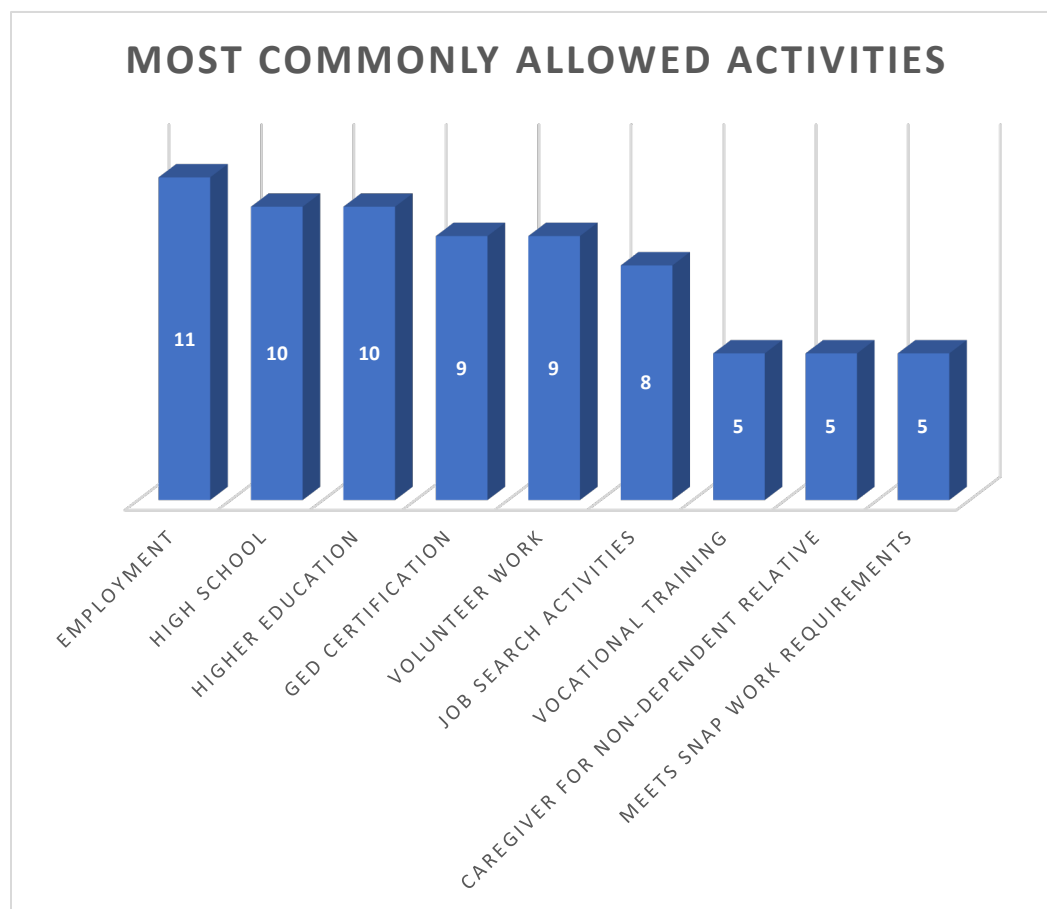


Figure 1.
Most common types of activities allowed by state for a Medicaid recipient to be in compliance with the proposed

work requirement.

Figure 1 depicts the most common activities a state will allow to satisfy the work requirement component of their Section 1115 waiver proposal. Of the 13 states, there were 36 different activities that would satisfy the work component. These activities varied by state, and a full list can be found in the appendices. While some activities were only proposed by one state, others

were proposed by several of the states. The nine most common activities allowed are shown in Figure 1.

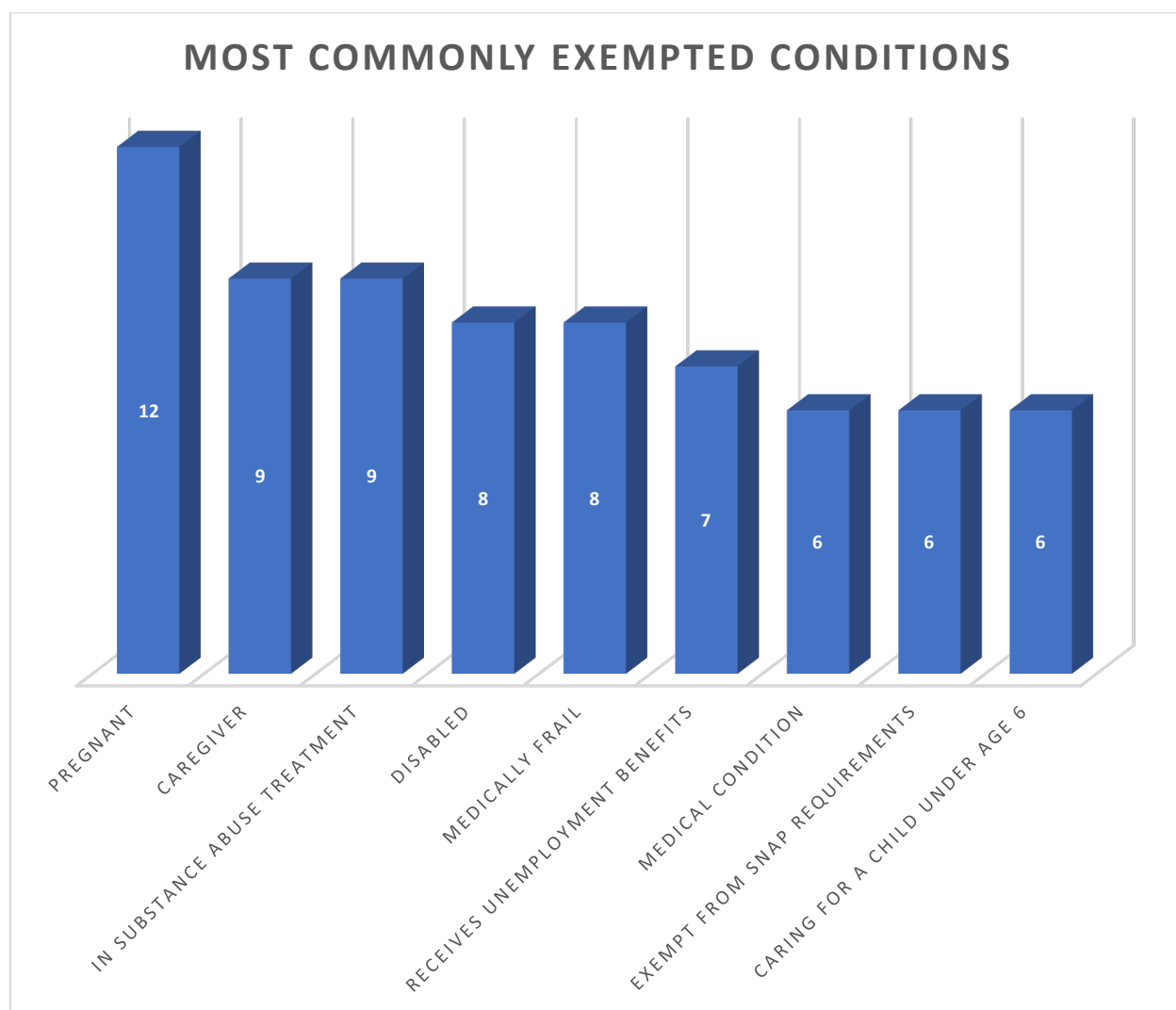


Figure 2. Most common conditions held by Medicaid recipients that states will allow exemption from the work requirement under their proposal to CMS.

Figure 2 depicts the most common conditions of a Medicaid recipient's life that a state will use to let a recipient qualify for an exemption from the work requirements posed in their 1115 waiver. Of the 13 states, there were 60 different categories that could result in an exemption. These allowed exemptions varied by state, and a full list can be found in the appendices. While some exemptions were only proposed by one state, others were proposed by several of the states. The nine most common conditions precipitating exemptions are shown in Figure 2. Note that the "Caregiver" category was outlined by the states specifically as a caregiver for a disabled child or adult.

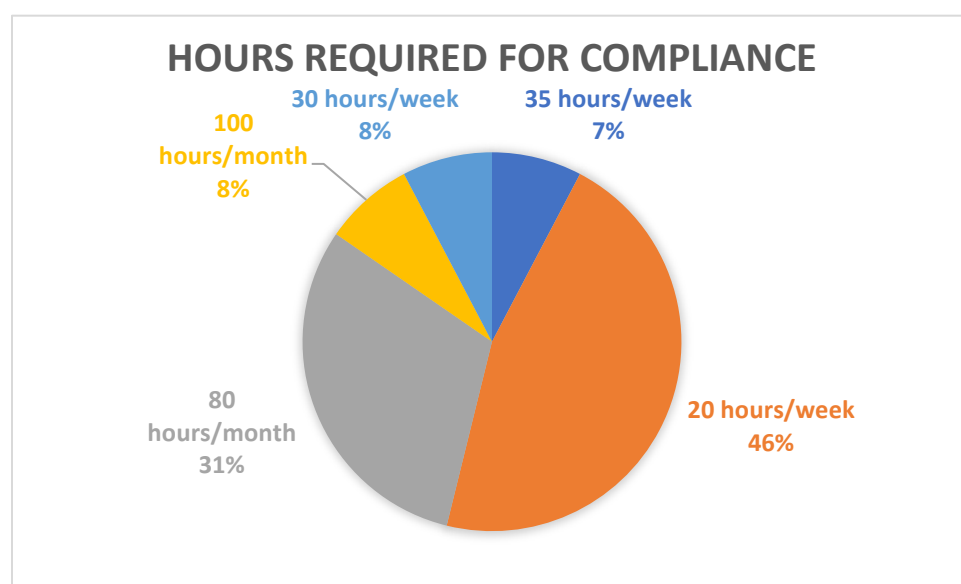


Figure 3. Hours required by states for Medicaid recipients to work in order to receive insurance coverage under the work requirement proposal.

Figure 3 represents the hours a state would require a Medicaid recipient to complete work activities in order to continue to receive Medicaid coverage. A majority of the states chose a weekly hour requirement rather than a monthly hour requirement. Six states required 20 hours/week, four states required 80 hours/month, and one state each chose 100 hours/month, 30 hours/week, and 35 hours/week.

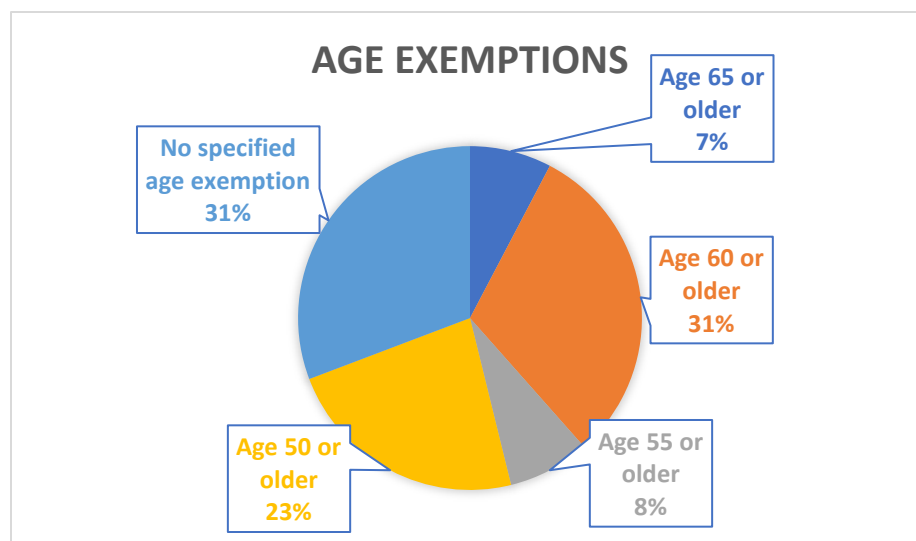


Figure 4. Age that a Medicaid recipient must be to be exempted from the work requirement under a state's proposal to CMS.

Figure 4 represents the age at which a Medicaid recipient, under each state's 1115 waiver proposal, would be exempt from the work requirement component of the state's Medicaid program. Four states did not specify any age exemption—which was the largest category, tied with the four states that would exempt Medicaid recipients age 60 and up. Three states would exempt Medicaid recipients age 50 and up from the age requirement, while one state would exempt those age 55 and up, and one other state would exempt those age 65 and up.

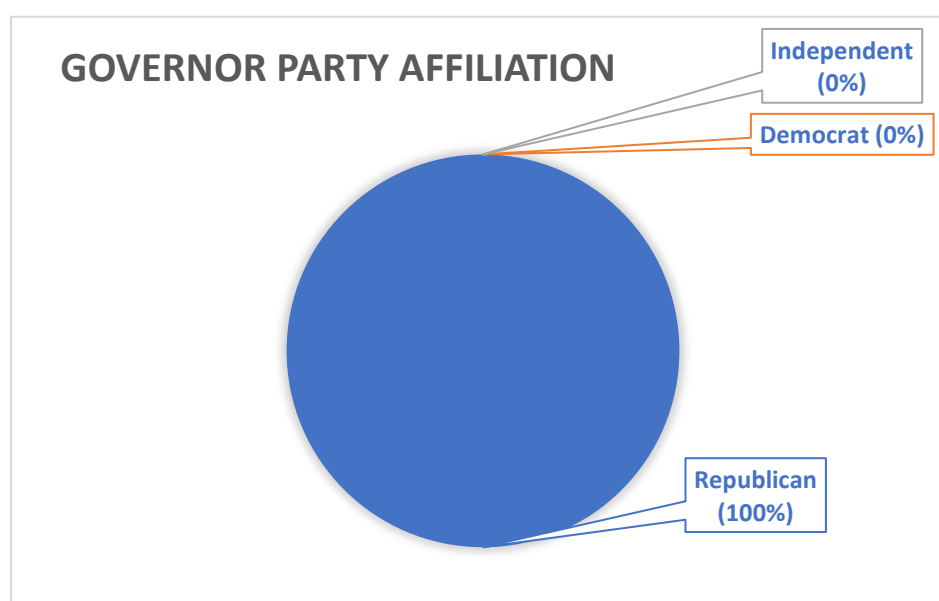


Figure 5. Party affiliation of the governor in states that proposed a work requirement.

Figure 5 represents the party affiliation of the governor of

each state who has proposed a work requirement. All states studied in this paper were led by a Republican governor when they submitted their work requirement proposal to CMS. These party affiliations are accurate as of October 2018, keeping in line with the cutoff date chosen by the author for work requirement proposals studied. However, some states may have experienced changes in the governorship's party after the November 2018 elections.

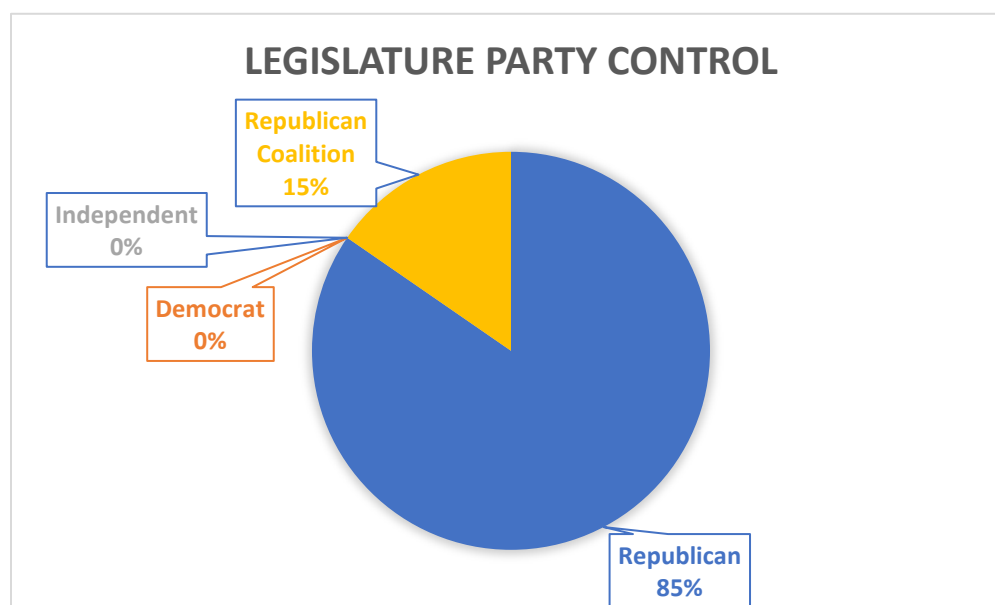


Figure 6. Party that controlled the state legislature in states that proposed a work requirement.

Figure 6 represents the party affiliation of the party in control of the legislative branch of each state who has proposed a work requirement. 11 states were under the control of a Republican majority, while 2 states were controlled by a coalition of moderate and conservative legislators. These party affiliations are accurate as of October 2018, keeping in line with the cutoff date chosen by the author for work requirement proposals studied. However, some states may have experienced changes in the legislature's majority party after the November 2018 elections.

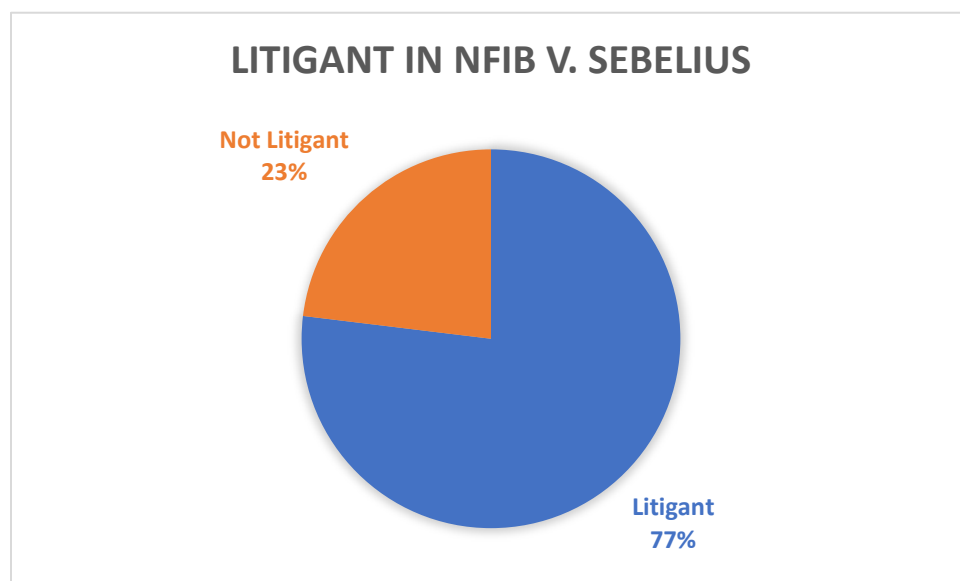


Figure 7.
Percentage of states who proposed a work requirement that signed on as litigants in NFIB v. Sebelius.

Figure 7 depicts the percentage of states examined in this paper that were and were not litigants in the NFIB v. Sebelius suit that was intended to declare the ACA unconstitutional. Ten states were litigants in the lawsuit, while three states were not litigants.⁶⁹

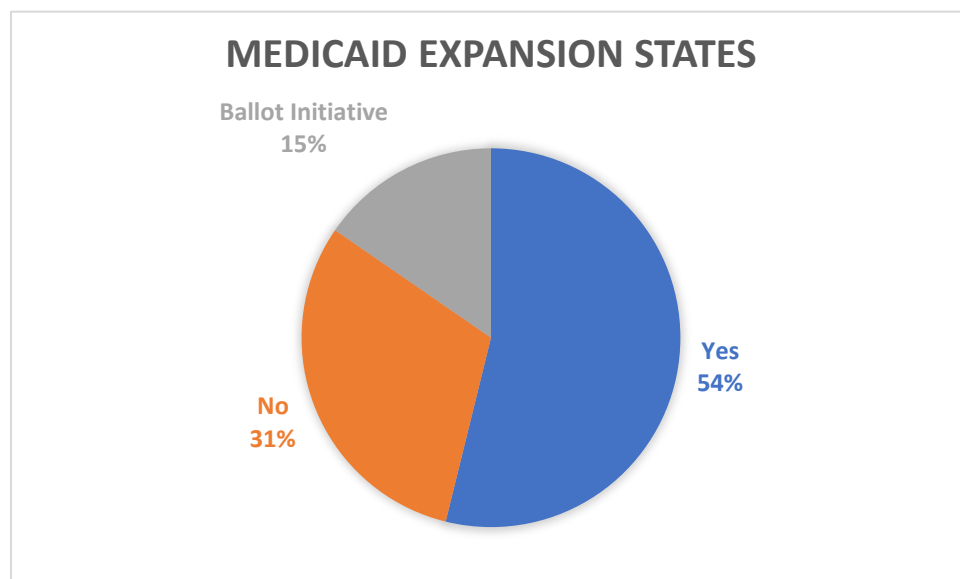


Figure 8.
Percentage of states who proposed a work requirement that expanded Medicaid under the ACA.

⁶⁹ "Florida v. Department of Health and Human Services," Kiera.

Figure 8 depicts the percentage of states examined in this paper that did or did not expand Medicaid under the ACA. Seven states have expanded Medicaid, four have not expanded Medicaid, and two states have expansion pending post a successful ballot initiative. Maine voters in 2017 voted by ballot initiative to expand Medicaid, but former governor Paul LePage refused implementation until his term ended in 2018.⁷⁰ The newly elected governor, Janet Mills, intends to move forward with the implementation of the expansion as of January 2019.⁷¹ A ballot initiative in Utah in November 2018 also saw voters approving Medicaid expansion.⁷² However, current lawmakers in Utah are attempting to curtail this effort.⁷³ The Medicaid expansion fight in Utah could be considered currently ongoing.

Discussion

This paper is attempting to answer the research question: are Medicaid work requirements an innovative way to assist Medicaid recipients, or are they a punitive way to lessen the budgetary burden on states, while sacrificing the health of the citizens served by Medicaid? 13 states have proposed to CMS the addition of work requirements to their Medicaid programs through the Section 1115 waiver mechanism. As of October 1, 2018, when I stopped evaluating new proposals (due to time and scope restraints), one state, Arkansas, had received approval for their work requirements program from CMS. There is data on outcomes for Medicaid recipients in the months since the approval of the Arkansas work requirement proposal, which I will discuss below in addition to the results I have obtained from my own research.

⁷⁰ "Maine's New Governor Moves Ahead with Medicaid Expansion, Luhby.

⁷¹ Ibid.

⁷² "Utah GOP Shrinks Medicaid Expansion, Defying Voters," Pradhan.

⁷³ Ibid.

In addition, I will also discuss other research conducted by local journalists and health policy nonprofits about the proposals of some states. Then, I will reference and discuss literature that evaluates one of the core assumptions that the political conservatives who propose work requirements hold to: that the correlation between unemployment and poor health can be extended to a correlation between employment and excellent health. Finally, I will discuss any limitations of this study, state why my research is important to the broader field of Medicaid policy, and make recommendations for further research that could stem from this study.

In determining whether a state's work requirement program is primarily innovative or primarily punitive, I intend to look mostly at the scope of what a state allows under its work requirement proposal. For example, a state that only counts a few types of activities as "work" and exempts people with only a few select conditions from the work requirement would be a state I consider to be running a program of a more punitive nature.

Analysis of Work Activities Allowed

The 13 states examined during this project outlined in their 1115 waiver proposals 36 different activities that a Medicaid recipient could report that would allow them to be in compliance with the work requirement and keep their health insurance coverage. These proposals ranged from incredibly vague (see Wisconsin, who only specified that 80 hours per month of work must be completed) to very broad and complex (see Indiana and South Dakota, who each outlined 17 specifications apiece). Most states did at least specify that some form of traditional employment, high school, higher education, job training or job search activities, or volunteer work would qualify as adequate methods by which to satisfy the work requirement. However, only some states explicitly mentioned that meeting SNAP work requirements or TANF

would requirements would be enough to meet Medicaid work requirements. This could pose a potential issue, as some enrollees are a part of multiple government assistance programs.

There were several interesting and novel ideas proposed by some states that a person could participate in to successfully meet the work requirement. Some of these unique activities are listed below, along with the state(s) allowing these activities:

- Taking an accredited English as a Second Language class (ESL): **IN, SD**
- Being self-employed: **AR, ME, MI, MS**
- Teaching an accredited homeschooling program: **IN**
- Participating in an internship: **MI**
- Participating in a tribal employment program: **MI**
- Taking a financial literacy course: **SD**
- Taking a disease management course: **SD**
- *Unique requirement*—work requirement only applies to residents of Minnehaha or Pennington Counties, the two most populous counties of **SD** (proposed under the assumption that finding employment in the most rural areas of the state will be difficult under conditions of nearly full employment)

The broad-ranging nature of these activities is, in some ways, a suggestion that these states are taking an innovative rather than punitive approach to Medicaid policymaking. For the states who did propose a broad range of work activities (AR, IN, NH, ME, and SD; I defined broad as states with 13 or more activities allowed), it is possible that the thought process behind proposing such a broad range of activities was meant as a flexible and tolerant approach to Medicaid enrollees. However, I would caution making this assessment without considering some of the issues with the activities proposed and the overall picture of each state's proposed

program. For example, Medicaid enrollees may face transportation issues, whether by being unable to afford a vehicle of their own or living in an area lacking public transportation, that could make it difficult to attend activities like disease management classes.⁷⁴

Also, due to the need of 1115 waiver proposals to remain budget neutral, most of the states did not allocate increased financial resources towards the administrative work necessary to process the work requirement hour reporting information that would be submitted by a Medicaid recipient or to assist Medicaid recipients with troubleshooting any issues that may occur while reporting their work hours. Overall, there is a significant amount of variation between states on how lenient or strict their requirements are surrounding allowed work activities and work requirement reporting. There were fewer examples of states that had a broad range of allowed activities and more examples of states that had a narrow range of allowed activities.

Analysis of Exemptions Allowed

The 13 states examined during this project proposed 60 different conditions that would allow a Medicaid recipient to claim an exemption from the work requirement component of the state's Medicaid program. The amount of exemptions allowed varied greatly by state, from quite strict (see Kentucky, whose proposal that was eventually invalidated by the courts allowed exemptions in only three cases) to broader and more wide-ranging (see Utah, who allowed exemptions under 19 different conditions). Most states did allow exemptions for some of the most common conditions that can prevent someone from work, such as: pregnancy, being a caregiver for a disabled child or adult, participating in substance abuse treatment, being disabled or medically frail, having a severe medical condition, receiving unemployment benefits, meeting work requirements for SNAP, or caring for a child under the age of 6. There were some

⁷⁴ "Kentucky Rushes to Remake Medicaid as Other States Prepare to Follow," Goodnough.

innovative and unique approaches to what type of condition could precipitate an exemption. Some of these conditions, as well as the state(s) that allow such an exemption to be claimed, are listed below:

- American Indians: **AZ, UT**
- Former foster youth up to age 26: **AZ**
- Homelessness: **AZ, IN**
- Affected by natural disaster: **AZ, NH, UT**
- Incarcerated in the last six months: **IN, MI**
- Receiving cancer treatment: **MS**

Allowing broader circumstances for exemption claims, such as the categories outlined above, does in some ways speak to the more innovative nature of a state's program—or at least the ability of state government officials to respond to the needs of varying groups of stakeholders. For example, Arizona altered their exemption categories after speaking with tribal leaders in the state and determining that a work requirement would pose too much hardship to Native Americans, especially when recognizing the lack of employment opportunities on reservations. In that specific instance, Arizona's 1115 waiver did reflect an innovative approach to tackling a state culture-specific policy issue. However, some of the exemptions listed above are not state-specific issues but occur nationwide (such as homelessness, incarceration, or receiving cancer treatment). The fact that most states do not specifically outline those conditions as significant enough to prevent someone from working points towards a more punitive approach to policymaking.

There are even more issues with the exemptions outlined by states in their section 1115 waiver proposals. Only five states explicitly mention that an exemption can be allowed due to

“good cause”, a catchall category that allows an exemption if a person can prove hardship significant enough that it prevents work, while not being outlined in one of the other exemption categories. I believe the presence or lack of a good cause exemption in a state’s proposal is an extremely important measure of how innovative or punitive a state’s program is. Recognizing that unexpected and unique circumstances can impact a person’s ability to work, and accounting for these circumstances (instead of simply canceling a person’s access to health insurance) by allowing for good cause exemptions is a significant way a state can prove that their program does not have punitive underpinnings.

In addition to the lack of good cause exemptions, almost all of the states did not clearly outline the process a Medicaid recipient would need to undergo to apply for an exemption or allow an appeals process if their application for an exemption is denied. Also, because of the necessity for the 1115 waiver proposal to remain budget neutral, most states did not dedicate any increased amount of resources into the administrative work that would be necessary to process paperwork for exemption applications and assist Medicaid recipients in troubleshooting their applications. Overall, there is a significant amount of variation between states on how lenient or strict their allowed categories for exemption claims are. While there were fewer examples of states with strict exemption categories (only three states outlined fewer than 10 categories for exemption), there were significant areas where almost all states fell short from an exemptions process that was easily navigable for Medicaid recipients and cognizant of unique circumstances.

Analysis of Work Hours Required for Compliance

Of the 13 states examined in this project, six states required Medicaid recipients to report 20 hours/week, four states required 80 hours/month, and one state each chose 100 hours/month, 30 hours/week, and 35 hours/week in order to retain Medicaid enrollment. This means that 10 of

the 13 states require recipients to report hours that align with a standard part-time job. Eight of the states require recipients to meet weekly hour reporting requirements and five of the states require workers to meet monthly hour reporting requirements. When evaluating the proposals for their innovative versus punitive nature, it is important to consider the flexibility a certain provision affords Medicaid recipients. A monthly reporting requirement allows more flexibility for recipients because of the possibility for a recipient to allocate more or fewer hours per week if needed. Overall, there is variation between the states on the amount of work hours required to achieve compliance. Proposals with high levels of hours per time period and with shorter time periods allotted are more punitive than those with more flexible requirements.

Analysis of Age Exemptions

Of the 13 states examined in this project, there was no clear trend on what age a state would allow a Medicaid recipient would be exempt from the work requirement. Four states did not specify any age exemption, four states would exempt Medicaid recipients age 60 and up, three states would exempt recipients age 50 and up, one state would exempt those age 55 and up, and one other state would exempt those age 65 and up. There were no rationales laid out by the states in their 1115 waiver application for why they chose the age exemption they did, or the lack of age exemption. It would appear that the states with the most generous age exemption (at age 50 or above) would have the most flexible and least punitive proposal because they exempt the most people. Overall, however, I would caution that the age exemptions laid out by states are too variable to provide any conclusive information about the nature of state's work requirement proposals.

Analysis of Consequences for Failing to Meet Work Requirement Specifications

The 13 states examined in this project did all outline some form of consequences a Medicaid recipient would face for failing to meet the work requirement. The wording of each state's consequences as outlined in their 1115 waiver proposals differed slightly from each other. Some states simply detailed that failure to meet the work requirement would end in termination of enrollment, while others crafted more complicated regulations (see Maine, who reserves the right to terminate enrollment if three months of noncompliance by a Medicaid recipient occur in a 36-month period). Four states did explicitly mention that a Medicaid recipient whose enrollment is terminated may reenroll after 30 days of being compliant with the work requirement, but most of the other states did not mention that recipients who lost their coverage could have the opportunity to reenroll. While this may have been an oversight and those who lose coverage in those states could actually reenroll, not explicitly publicizing so could lead to confusion among recipients who may believe they will be permanently blocked from receiving the care they need.

Of the states, the most unique and troubling proposal came from Wisconsin—who asked CMS to be allowed to institute a lifetime limit on Medicaid benefits. In their proposal, Wisconsin asked to give Medicaid recipients a 48-month allowance where recipients could be in noncompliance with the work requirement. However, after those 48 months, recipients would never again be able to receive Medicaid in the state of Wisconsin. This aspect of Wisconsin's waiver proposal appears to me as rather punitive because most people do not keep detailed enough information to realize when their 48 months will have run out—leading to the surprise loss of coverage. If someone is dealing with the conditions or challenges that prevent them from participating in the labor market, those conditions may also prevent them from having the resources or understanding needed to find health insurance through another avenue. The

administrative burden that enforcing this requirement could place on the state of Wisconsin is also concerning, and adds to the fears that former Medicaid recipients will not have adequate time to plan how to get health coverage once their Medicaid runs out. Overall, there is a significant amount of variation between states on how lenient or strict their consequences for failing to comply with the work requirement are. However, all states, in some way or another, do levy the termination of enrollment as a consequence for failure to meet the work requirement—a punitive action by nature because of the consequences to one’s health and finances posed by being uninsured.

Analysis of Governor Party Affiliation

Of the 13 states examined for this project, all 13 had a governor who was a member of the Republican Party at the time they submitted their 1115 waiver proposal to CMS for evaluation. This factor presents an issue to me when determining if work requirement proposals have innovative or punitive underpinnings. I see programs that are innovative as taking novel, unique approaches to policymaking that address an actual problem. Innovative approaches attract sponsorship and acclaim in a cross-partisan manner because their unique nature means that parties do not have rigid, pre-established stances towards them. Overall, the lack of cross-partisan support for Medicaid work requirements, as shown by the party affiliation of the governors who propose these requirements, indicates to me that the policies are of a punitive nature.

Analysis of Legislature Party Control

Of the 13 states examined in this project, 11 had state legislatures that were controlled by a Republican majority at the time the state submitted its work requirement proposal to CMS. 2 states had legislatures in which conservatives had to create a coalition with moderates (possibly

between legislative chambers) to keep the legislative branch under Republican control.

Legislators that did not belong to the Republican party registered objections to work requirements during legislative debate in many states. Tony Evers, the Democrat who became governor of Wisconsin after the November 2018 elections, campaigned partially on his desire to rescind the work requirement proposal. The Republican-controlled Wisconsin legislature, however, voted to approve the work requirements, with all Democrats and one Republican in the legislature voting against the work requirements.⁷⁵ Again, the lack of cross-partisan approval of work requirements indicates to me a possibility that they are not a policy designed to consider the overall wellbeing of the citizens.

Analysis of State's Participation in NFIB v. Sebelius

Of the 13 states examined in this project, ten were litigants in the Supreme Court case NFIB v. Sebelius, in which the states attempted to have the ACA declared unconstitutional. Three states were not litigants in the case. This amounts to 77% of the states in this project that were litigants. Nationally, only 52% of states were litigants in the case. As NFIB v. Sebelius was brought by states with an ideologically antagonistic view towards the ACA, the disproportionate amount of states who proposed work requirements that were litigants in NFIB v. Sebelius is certainly not evidence that work requirements are an innovative policy approach. This is because, by being a litigant in the case, states were indicating their displeasure with some of the key stated goals of the ACA, such as to decrease the number of uninsured Americans, especially those in low-wage or part-time jobs whose employers did not offer insurance. By instituting a work requirement, states are creating the possibility that the uninsured rate will increase when Medicaid enrollees fail to comply with the work requirement.

⁷⁵ . "Wisconsin Republicans Lock in Medicaid Work Requirements to Block Incoming Democratic Governor," Leonard.

Analysis of State's Decisions on Medicaid Expansion

Of the 13 states examined in this project, seven had expanded Medicaid by October 1, 2018, four had not expanded Medicaid, and two had expansion pending in the aftermath of ballot initiative efforts in which the voters approved Medicaid expansion. This majority in favor of Medicaid expansion may seem confusing in the context of work requirement proposals because Medicaid expansion was an idea that many conservative states chafed against when it was originally proposed.⁷⁶ However, I believe the circumstances surrounding the ACA's existence currently have led these conservatives to seek to implement work requirements as a way to curtail the impacts of Medicaid expansion after failures to repeal the ACA entirely. After the Supreme Court ruled to uphold the existence of the ACA in *NFIB v. Sebelius*, and especially after the multiple failures at the federal level to repeal the ACA in 2017, Republican state politicians took matters into their own hands by proposing work requirements so as to better align the program with conservative values.^{77,78} Overall, I do not necessarily see a state's status on Medicaid expansion as useful when considering the intent and purpose of Medicaid work requirement proposals because voters are attempting to expand Medicaid by ballot initiative (a process that can proceed without the approval of state legislators). A state's Medicaid expansion status may be more useful in other areas, such as trying to predict if CMS will approve or deny the state's 1115 waiver. For example, CMS may be less likely to give a non-expansion state approval for a work requirement because that work requirement could pose an undue burden on the state's current Medicaid recipients, many of whom are likely experiencing deep poverty.

Supplemental Analysis

⁷⁶ "Florida v. Department of Health and Human Services," Kiera.

⁷⁷ Ibid.

⁷⁸ "Republican Effort to Repeal the ACA, July 2017," Ballotpedia.

In addition to reviewing the results of my own research, I reviewed findings from journalism outlets and health policy non-profit organizations that have also written about Medicaid work requirements. Specifically, these organizations reviewed the work requirements of Arkansas, Indiana, and Mississippi. I chose to reference these sources because they present some of the most comprehensive reporting and research on a policy area that is still evolving. Of these states, Arkansas was the first to gain CMS approval for its work requirements program, Arkansas Works. Indiana presents an interesting case because their proposal was one of the most wide-ranging in its exemptions allowed. Study of Mississippi is unique because Mississippi is one of the states with a more strict 1115 waiver proposal, and that has also not expanded Medicaid.

Arkansas gained approval for its work requirement program and began implementation in 2018. By the end of November 2018, after the first three months of the program in which a recipient's enrollment could be terminated, over 16,000 Arkansans lost their Medicaid coverage.⁷⁹ Only about 2% of those eligible for Arkansas Works met the work requirement in the first month of its operation.⁸⁰ One state official claimed this low participation rate was because Medicaid recipients "don't value the insurance."⁸¹ Other state officials claimed that this enrollment drop was due to people obtaining other insurance coverage, moving out of state, or not having a desire to participate in the workforce—but independent analyses confirmed there were also significant barriers for many recipients that made compliance with the work requirement an issue.⁸² Until recently, Arkansas Works hours could only be reported through an online portal described as "confusing and glitchy" that shut down for maintenance every night

⁷⁹ "Conservative Health Care Experiment Leads to Thousands Losing Coverage," Pradhan, et. al.

⁸⁰ "One Big Problem With Medicaid Work Requirement: People Are Unaware It Exists," Sanger-Katz.

⁸¹ "With New Work Requirement, Thousands Lose Medicaid Coverage in Arkansas," PBS.

⁸² "Update: Arkansas's Work Requirement Drops Another 4,100 from Medicaid in October," Hardy.

from 9 pm to 7 am.⁸³ Arkansas has the lowest rate of internet penetration of any state, and researchers from the Urban Institute found that 25% of those projected to lose Medicaid coverage under the new rule had no internet access in their household.⁸⁴ While the state did attempt to adjust to this demand by allowing reporting at online kiosks in government offices, many of these offices are only open during standard business hours—which makes going to an office and reporting work hours challenging for someone working a low-wage job without the benefit of consistent scheduling.⁸⁵ In addition, Arkansas refused to allocate any additional resources to assist Medicaid recipients in the job search process, and many found the Arkansas Works advertising campaign to be ineffective and not go far enough to make people aware of the work requirement.^{86,87} During a national period of low unemployment, in a state with many rural areas that lack abundant job prospects, the unwillingness of the government to dedicate resources to workforce development after requiring citizens to work to receive health care is telling.⁸⁸

Overall, considering the results thus far out of Arkansas is very important when analyzing the intent of Medicaid work requirement proposals. As the first state to actually run the program, results from Arkansas lend real people with real stories and real challenges to the debate about the effectiveness of these novel policies. Considering these human stories in conjunction with the data gathered in this project brings me to the conclusion that work requirements are punitive—or at least ineffective policies. While even many Medicaid recipients themselves have not called the idea of the work requirements unreasonable, results from Arkansas demonstrate

⁸³ Ibid.

⁸⁴ "Medicaid Work Requirements: What Do We Know About Them and Who Will Be Affected by Them?" Gangopadhyaya, et. al.

⁸⁵ "Conservative Health Care Experiment Leads to Thousands Losing Coverage," Pradhan, et. al.

⁸⁶ "With New Work Requirement, Thousands Lose Medicaid Coverage in Arkansas," PBS.

⁸⁷ "One Big Problem With Medicaid Work Requirement: People Are Unaware It Exists," Sanger-Katz

⁸⁸ "With New Work Requirement, Thousands Lose Medicaid Coverage in Arkansas," PBS.

that the programs are unable to accomplish their stated policy goals and outcomes of improving the health and independence of Medicaid enrollees. In addition, Arkansas has run into the classic problem that comes with attempting to change people's behaviors as a way to motivate their health outcomes: people won't change their behavior if they don't realize that the rules tying their behavior to cuts in their health coverage exist. In this case, Arkansas was attempting to motivate people to change their behavior surrounding employment, but refused to adequately advertise (or lacked the resources to do so) to Medicaid recipients that this behavior was about to be tied to their ability to receive care.

In Indiana, the human stories of those who may be impacted by the work requirement are worrisome, despite the more expansive nature of the exemptions the state allows enrollees to claim. For many Medicaid recipients at, near, or below the poverty line who have nontraditional employment situations, Indiana's guidelines (which are among the most specific and extensive of all the states studied in this paper) are unclear, confusing, and concerning. One citizen, for example, who works as a massage therapist and a singer-songwriter, is worried about how her work would meet the requirement—her hours per week fluctuate by nature based on how frequently her clients wish to make appointments.⁸⁹ Another who works at a lawn-care business worries about meeting the work requirement in the winter months, paralleling the concerns of those in Indiana who are seasonally employed.⁹⁰ Other recipients were ensnared in paperwork glitches in the fledgling system and were stuck with expensive bills they did not have the ability to pay.⁹¹ These concerns on the margins in Indiana may seem like just that: on the margins, but when you're creating policy that could result in the termination of citizen's access to life-saving

⁸⁹ "Indiana Medicaid Work Requirements Fuel Worries for the Poor," Varney, et. al.

⁹⁰ Ibid.

⁹¹ Ibid.

care, the margins matter. Evidence from Indiana so far also lends itself to the idea that Medicaid work requirements are a punitive, rather than innovative policy.

Analysis of Mississippi's 1115 waiver proposal produces findings that illustrate how Medicaid work requirements can be the worst-case scenario for families in deep poverty. Unlike many of the other states studied in this paper, Mississippi has refused to expand Medicaid—instead only allowing its citizens to qualify for Medicaid if they make less than \$5,610 a year to support a family of three (equivalent to earning 27% of the federal poverty level).⁹² Alker, et. al from the Georgetown University Health Policy Institute note that Mississippi has no plans to provide the supports needed for extremely poor Mississippians with children to be able to comply with the work requirement, such as child care subsidies, job training, or transportation opportunities.⁹³ These scholars found that Mississippi's waiver application seems to be aimed at reducing Medicaid enrollment and cutting costs.⁹⁴

This sentiment is echoed when examining Mississippi's original 1115 waiver application containing work requirements, which was denied by CMS because of the catch-22 scenario it created for its recipients and for containing rhetoric about using the waiver to save the state money and “preserving the program for the truly needy.”⁹⁵ For those Medicaid recipients with an income low enough to qualify in Mississippi, finding a job so as to comply with the work requirements would result in earning enough money to lose eligibility for Medicaid but not enough to afford private health insurance.⁹⁶ If a Medicaid recipient refused to comply with the work requirement, their enrollment would be terminated anyway.⁹⁷ Demographics analysis of

⁹² “How Mississippi's Proposed Medicaid Work Requirement Would Affect Low-Income Families with Children,” Alker, et. al.

⁹³ Ibid.

⁹⁴ Ibid.

⁹⁵ “The Health 202: Mississippi Quietly Amends Its Medicaid Work Requirement Waiver,” Itkowitz.

⁹⁶ Ibid.

⁹⁷ Ibid.

the Medicaid recipients in Mississippi was used to determine who would likely be impacted by this catch-22 scenario and would lose coverage. The vast majority were African-American single mothers living in rural areas.⁹⁸ When considering this data in conjunction with the rhetoric from state officials about the “truly needy,” this is a startling and worrisome finding. Overall, the conditions in Mississippi that predate the state’s work requirement proposal exacerbate the punitive outcomes that would be likely borne out of the work requirement.

To complete my analysis about the intent and efficacy of Medicaid work requirements, I turned to the literature surrounding the correlation between employment and positive health outcomes. One common rhetorical device employed by the conservative state officials who have proposed Medicaid work requirements is that “being employed is better for your health.”⁹⁹ However, the evidence is limited on whether or not this claim that undergirds nearly all of the proposals I have studied is actually true.¹⁰⁰ While the opposite is certainly supported by ample evidence (that unemployment is correlated with poor health outcomes), researchers caution that applying that correlation towards employment and positive health is not advisable for a number of reasons.¹⁰¹ Antonisse, et. al from the Kaiser Family Foundation, one of the nation’s premier health policy non-profit outlets for research and journalism, explained best in 2018 why this leap is not factually sound:

“Most studies that assess work and health are surveying a wide swath of the population, and not just individuals who may be in low-wage, poor-quality jobs. While there is a correlation between unemployment and bad health...Kaiser researchers caution against

⁹⁸ “How Mississippi’s Proposed Medicaid Work Requirement Would Affect Low-Income Families with Children,” Alker, et. al.

⁹⁹ “Improving Medicaid,” Price and Verma.

¹⁰⁰ “The Relationship Between Work and Health: Findings from a Literature Review,” Antonisse, et. al.

¹⁰¹ Ibid.

using that as evidence that work would then be the cure without considering other variables. Moreover, when someone takes a job or volunteers out of fear of losing needed benefits, it may not have the same positive effects as doing so of their own volition...Given the characteristics of the Medicaid population, research indicates that (these) policies could lead to emotional strain, loss of health coverage, or widening of health disparities for vulnerable populations.”^{102,103}

Overall, Medicaid recipients have too many variables in their lives that make it too challenging to derive any true correlation between employment and positive health outcomes from the research in the field available at this time.

I do acknowledge that this paper has a few limitations. First, due to the time necessary to read and analyze the 1115 waiver proposal of each state, I had to limit my analysis to any proposals submitted before October 1, 2018. As this policy area continues to evolve, more states have submitted or are in the process of submitting 1115 waiver applications. Stronger conclusions could be garnered with a larger sample size of states—this would be a nice route to pursue for further research in the field. Second, I believe incorporating enrollment number results from more states would have been beneficial. As more states get their programs approved by CMS and begin implementation, there will be a clearer picture about the outcomes that work requirements for Medicaid produce. However, I believe these limitations do not prevent me from making conclusions in this paper because I was still able to use the comprehensive nature of the information provided in an 1115 waiver application in my analysis.

¹⁰² "The Relationship Between Work and Health: Findings from a Literature Review," Antonisse, et. al.

¹⁰³ "The Health 202: Mississippi Quietly Amends Its Medicaid Work Requirement Waiver," Itkowitz.

In this paper, I examined several factors to try and determine if work requirements for Medicaid are innovative or punitive measures. After examining the types of activities that would be in compliance with the work requirements, the categories of exemptions allowed under each state's proposal, the work hours required for compliance, the age exemptions allowed in each proposal, the consequences for failing to meet the work requirement, the party affiliation of the governor of each state who proposed a requirement, the party control of the state legislature, the state's status as a litigant in *NFIB v. Sebelius*, the state's decision on Medicaid expansion, and referencing other literature in the field about the results of work requirements in states so far, I have concluded that work requirements are punitive policy measures, rather than innovative efforts. A more extensive summary of the reasoning behind this decision can be found in the conclusion section of this paper.

The analysis I conducted in this paper is of great importance to the field of health policy. As CMS under the Trump administration continues to assert its authority in setting guidelines for the states regarding 1115 waiver experimentation, research will become increasingly necessary to determine what the impacts of these experimental approaches are to the citizens receiving care under Medicaid. This action by a bureaucratic agency and by state legislatures is currently understudied and underrecognized, but still has the potential to be a harmful policy to a significant number of Americans. My research has attempted to perform this analysis with the preliminary amounts of information that are available to the public.

Conclusion

In this paper, I attempt to evaluate whether the Medicaid work requirements proposed by 13 states as of October 1, 2018 are an innovative or punitive policy measure. I did this by first establishing a knowledge base about the history of Medicaid, Medicaid and the Affordable Care

Act, and the outcome of work requirements in past federal programs. I then compared the proposals across eight different areas to discern how flexible or strict the work requirement was in its administration. Finally, I analyzed supplemental literature about the results in states that have rolled out their work requirement or hope to do so soon. I found that adding work requirements to Medicaid is an unprecedented, punitive measure whose early results have been ineffective at lifting Medicaid recipients to independence and has resulted in thousands of Americans losing their health insurance coverage. While this result may not have been the intent of some state legislators and government employees, there is mounting evidence that the outcomes that have resulted so far for Medicaid beneficiaries have been disastrous—so intent alone can't represent the full picture of a policy's worth. I recognize that the individual elements of a work requirement seem reasonable to many people: that they believe spending a few hours each week working, volunteering, or contributing to one's community is a fair price to ask in return for health insurance at no other cost. However, I take issue with the exorbitant monetary costs that administration and advertising of these work requirements would bring. The main problem comes with the mechanism of rescinding coverage based on someone failing to complete an action they are unaware is being mandated of them. That is an approach that I believe fundamentally devalues human life.

Lastly, it's important to note that placing work requirements on Medicaid seems to be based in a misconception about the population that comprises Medicaid enrollees. There are relatively few cases comparatively of Medicaid recipients that refuse to work or have no desire to work.¹⁰⁴ Rather, it is estimated that 60% of Medicaid recipients are already employed.¹⁰⁵ Of those not working, 90% have reported reasons such as illness or disability, being retired, taking

¹⁰⁴ "Understanding the Intersection of Medicaid and Work," Garfield, et. al.

¹⁰⁵ Ibid.

care of home or family, or going to school that justifiably prevent their participation in the labor market.¹⁰⁶ In most states, the administrative costs and rhetorical posturing that have gone into implementing Medicaid work requirements have been going towards (intentionally or unintentionally, after completion of the exemption process) mandating the behavior of relatively few enrollees. As we've seen, many of these Medicaid enrollees face serious challenges to holding employment or earning an increased income. With those conditions in mind, Medicaid work requirements appear to be punitive measures. State and federal officials should consider these issues when making decisions about the future of their Medicaid programs.

¹⁰⁶ "Understanding the Intersection of Medicaid and Work," Garfield, et. al.

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Appendix 1

Appendix 1 includes a citation of and link to every state's Section 1115 waiver proposal that I examined as a part of my research for this project, listed in alphabetical order by state.

Alabama

"State of Alabama Medicaid Workforce Initiative Section 1115 Demonstration Application."

Alabama Medicaid Agency. September 10, 2018. Accessed February 23, 2019.

https://www.medicaid.alabama.gov/documents/2.0_Newsroom/2.7_Special_Initiatives/2.7.5_Work_Requirements/2.7.5_2nd_Comment_Period/2.7.5_Work_Requirements_Waiver_App_9.10.18.pdf.

Arkansas

"Arkansas Works Work and Community Engagement Requirements." Arkansas Department of Human Services. August 13, 2018. Accessed February 23, 2019.

<https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-cmmnty-engagement-draft-eval-dsgn-20180813.pdf>.

Arizona

“Arizona Section 1115 Waiver Amendment Request: AHCCCS Works Waiver.” Arizona Health Care Cost Containment System. January 3, 2018. Accessed February 23, 2019.

<https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-pa6.pdf>

Indiana

“Amendment Request to Healthy Indiana Plan (HIP) Section 1115 Waiver Extension Application.” Indiana Family and Social Services Administration. July 20, 2017.

Accessed February 23, 2019. <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-demo-app-07202017.pdf>

Kentucky

“Helping to Engage and Achieve Long Term Health.” Kentucky Health. July 19, 2018.

Accessed February 23, 2019. <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa3.pdf>

Maine

“1115 Waiver Application.” Maine Department of Health and Human Services. August 2, 2017.

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Michigan

“Healthy Michigan Plan Section 1115 Demonstration Extension Application.” Michigan Department of Health and Human Services. September 10, 2018. Accessed February 23, 2019.

https://www.michigan.gov/documents/mdhhs/Amended_Section_1115_Demonstration_Extension_Application_-_Clean-Web_Posting_632189_7.pdf

Mississippi

“Medicaid Reform Demonstration Project Medicaid Workforce Training Initiative.” State of Mississippi. May 29, 2018. Accessed February 23, 2019.

<https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ms/ms-workforce-training-initiative-pa2.pdf>

New Hampshire

“Granite Advantage 1115 Waiver Amendment and Extension Application.” State of New Hampshire. July 23, 2018. Accessed February 23, 2019.

<https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ms/ms-workforce-training-initiative-pa2.pdf>

Ohio

“Group VIII Work Requirement and Community Engagement 1115 Demonstration Waiver.”

Ohio Department of Medicaid. April 30, 2018. Accessed February 23, 2019.

<https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/oh/oh-work-requirement-community-engagement-pa.pdf>

South Dakota

“Career Connector: A South Dakota 1115 Demonstration Proposal.” Department of Social Services. August 10, 2018. Accessed February 23, 2019.

https://dss.sd.gov/docs/medicaidstateplan/career_connector_application.pdf

Utah

“1115 Primary Care Network Demonstration Waiver.” State of Utah Department of Health.

June 22, 2018. Accessed February 23, 2019. <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/ut-primary-care-network-pa4.pdf>

Wisconsin

“Request to Amend Wisconsin’s Section 1115 BadgerCare Reform Demonstration Project .”

State of Wisconsin Department of Health Services. June 7, 2017. Accessed February 23, 2019. <https://www.dhs.wisconsin.gov/badgercareplus/clawaiver-finalapp.pdf>

Appendix 2

Appendix 2 includes the full charts I used to document what work activities would count when calculating compliance with the work requirement in each state. These are located on pages 55 and 56. Pages 57-59 show the full charts I used to document which exemptions states will allow. Page 60 shows the full chart in which I documented the consequences of failing to meet the work requirement in each state.

Work Requirement Category	AL	AR	AZ	IN	KY	ME	MI	MS	NH	OH	SD	UT	WI	Total
35 hours/week	X													1
20 hours/week	X		X	X	X	X				X				6
Employment	X	X	X	X	X	X	X	X	X	X	X			11
On the job training	X	X							X					3
Job search activities	X			X	X		X		X	X	X			7
High school	X	X	X	X	X	X	X		X	X	X			10
GED certification	X	X	X	X	X	X			X	X	X			9
Higher education	X	X	X	X	X	X	X		X	X	X			10
Volunteer work	X	X		X	X	X	X	X	X		X			9
Technical training	X													1
At least 19 years old			X											1
Ages 19-49		X												1
80 hours/month		X					X				X		X	4
Self-employment		X				X	X	X						4
Vocational training		X		X	X		X		X					5
Job search (40 hrs/mo)		X												1
Job search training (40 hrs/mo)		X												1
Class on healthy living (20 hrs/yr)		X									X			2

